STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087226	A. BUILDING: _____ B. WING _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEEPSAKE KOTTAGE #2	6412 E MARJORIE WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey for the above named facility conducted on 02/01/24 and 02/05/24.	S 000		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of six residents (R). The sample included three residents. Based on interview and record review the operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time, action taken, and results of the action for three (R3, R4, and R5) of three sampled residents. Findings included: - R3's medical record revealed she moved into the facility on 09/27/22 with diagnosis of Cerebrovascular accident (CVA) (stroke) - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain. R3's "Functional Capacity Screen" dated 01/29/24 revealed she was not able to participate in	S5251		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S5251	Continued From page 1	S5251		

activities of daily living and dependent on staff for all cares. She was not able to manage her medications, had bladder incontinence, and impaired cognition.

R3's "Negotiated Service Agreement" dated 01/29/24 revealed she required assistance of two staff for transfers using a mechanical lift, had local Home Health agency to provide medications and feedings via Peg-tube (Gastrostomy feeding- the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall). Facility staff were to provide assistance of one to two staff to provide all activities of daily living.

Review of R3's medical record included the following "Nurse's Notes" from 02/20/23 to 02/01/24:
Many of these nursing notes lacked a time as to when the occurrence happened or note was written.
05/24/23 - New order for Nystatin (antifungal medication) powder to inguinal creases. The record lacked follow up as to the effectiveness of the Nystatin powder.
07/15/23 - The resident had blood in her brief and a history of hemorrhoids with a suppository ordered. The record lacked follow up as to the effectiveness of the suppositories.
11/19/23 - The resident required Preparation-H suppositories orders for hemorrhoids for twice a day times one week. The record lacked follow up as to the effectiveness of the suppositories.

On 02/05/24 at 02:06 PM Administrative Licensed Nurse B reported the expectation for nursing staff was to document monthly on each resident and then document by exception as incidents occurred. Staff were to follow up on their

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S5251	Continued From page 2 documentation and interventions. The operator failed to ensure designated staff included time of occurrences and follow up on the effectiveness of new medications / treatments for specific symptoms. - R4's record revealed she moved into the facility on 03/31/21 with diagnosis of dementia. R4's "Functional Capacity Screen" dated 06/15/23 revealed she required physical assistance with all activities of living except for eating in which she needed supervision. She could not manage her medications, had bladder incontinence, and impaired cognition. R4's "Negotiated Service Agreement" dated 06/15/23 revealed staff provided assistance of one with activities of daily living, qualified staff administered all medications, and provided cueing throughout the day related to impaired cognition. R5's medical record included the following "Nurse's Notes": 05/24/23 - The resident started Acyclovir for shingles. The record lacked documentation related to any symptoms related to shingles and effectiveness of medical treatment. 07/10/23 - The resident had swollen legs and a new order to increase Lasix (diruetic medication). The record lacked follow up related to effectiveness of the increase in Lasix. The record also included multiple entries with no documentation of time associated with the entry or the occurrence of symptom. On 02/05/24 at 02:06 PM Administrative Licensed Nurse B reported the expectation for nursing staff	S5251		

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S5251	Continued From page 3	S5251		

was to document monthly on each resident and then document by exception as incidents occurred. Staff were to follow up on their documentation and interventions.

The operator failed to ensure designated staff included time of occurrences and follow up on the effectiveness of new medications / treatments for specific symptoms.

- R5's medical record revealed she moved into the facility on 10/23/23 with a diagnosis of cognitive impairment.

R5's "Functional Capacity Screen" dated 10/23/23 revealed she required physical assistance with all activities of daily living, could not manage her medications, had bladder incontinence, and impaired cognition. The functional capacity screen did not identify she had any inappropriate behaviors.

R5's "Negotiated Service Agreement" dated 10/23/23 revealed she needed assistance of one staff member for activities of daily living and she needed assistance of two staff for transfers. The "Negotiated Service Agreement" did not include services related to behaviors.

Review of R5's medical record included the following nursing "Nurse's Notes", many of which did not have a time indicating when the note was documented.
10/24/23 - The writer received a call from staff stating the resident attempted to hit during cares, was given space, and staff tried to provide cares again later, and was successful. The entry lacked a signature of who wrote it and time it was written. The next page of notes had four different entries, none of which had a time associated to the entry.

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S5251	Continued From page 4 10/25/23 - The resident had a new order for Lorazepam (antianxiety medication) due to anxiety. 10/25/23 - The resident had a new order for Haldol (antipsychotic medication) for behaviors. 10/25/23 - Staff would obtain a urine sample for the resident due to increased confusion. 10/26/23 - The resident had an order for Nystatin (antifungal medication) powder for groin irritation. The record lacked documentation of what the residents behaviors were and nurse follow up as to the effectiveness of the Haldol and the Lorazepam. 11/6/23 - New order to increase Trazadone to 50 milligrams (mg). 11/14/23 - New order to increase Trazadone to 75 mg. The record lacked documentation of the results of increasing the Trazadone. 11/15/23 - The resident required Keflex (antibiotic medication) for cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling to both lower legs). The record lacked documentation as to the effectiveness of the Keflex and healing cellulitis. 11/22/23 - New Order for Home Health to evaluate and treat wound and lymphedema. The record lacked documentation of the facility nurse related to wound and effectiveness of current treatment plan. On 02/05/24 at 02:06 PM Administrative Licensed Nurse B reported the expectation for nursing staff was to document monthly on each resident and then document by exception as incidents occurred. Staff were to follow up on their documentation and interventions. The operator failed to ensure R5's record included documentation of all symptoms to require need for starting antipsychotic	S5251		

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S5251	Continued From page 5 medications and antibiotics, including the date and time of occurrence, action taken and results of action. The operator failed to ensure R5's medical record included the results of action taken related to R5's medical concerns.	S5251		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of six Residents (R), with three residents included in the sample. Based on record review and interview the operator failed to ensure staff administered medications according to a Medical Providers	S5300		

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S5300	Continued From page 6 written order for R5 who the facility was responsible for administering medications. Findings included: - Review of R5's medical record revealed she moved into the facility on 10/23/23 with a diagnosis of cognitive deficit. R5's "Functional Capacity Screen" dated 10/23/23 revealed she was unable to manage medications and had impaired cognition. R5's Negotiated Service Agreement dated 10/23/23 revealed qualified staff administered R5 her medications. Review of R5's "Physician Orders" revealed the following: 11/06/23 - Discontinue Trazadone (antidepressant) 25 milligrams (mg) and start Trazadone 50 mg at bedtime. 11/14/23 - Discontinue Trazadone 50 mg and start Trazadone 75 mg at bedtime. 12/13/23 - Increase Trazadone to 75 mg at bedtime and discontinue the 50 mg dose. Review of the November 2023 "Medication Administration Record" (MAR) revealed the Trazadone was increased to 50 mg on 11/06/23 and the facility failed to increase to the 75 mg on 11/14/23 as ordered. R5's "Nursing Notes" included documentation on 12/13/23 that she continued to have restless nights despite taking Trazadone 50 mg. On 02/05/24 at 02:08 PM Administrative Licensed Nurse B reported the nurse should have changed the MAR when she got the order on 11/14/23 to	S5300		

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S5300	Continued From page 7 indicate the increased dosage to ensure R5 received the correct ordered dosage. The operator failed to ensure R5 received an increased dosage in medication as the physician had ordered.	S5300		